APPEAL NO. 93428

This appeal arises under the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. art. 8308-1.01 *et seq*. (Vernon Supp. 1993) (1989 Act). A contested case hearing was held on April 22, 1993, in (city), Texas, before hearing officer hearing officer). The three issues were whether the great weight of medical evidence is contrary to the finding of the designated doctor, who assessed maximum medical improvement (MMI) with a 10% impairment rating on December 27, 1991; whether the claimant is precluded from disputing MMI pursuant to Rule 130.5(e), because she did not dispute the finding within 90 days; and, if it is found that MMI has not been reached, whether claimant has been able to obtain and retain employment at any time between December 28, 1991, to the date of the hearing. The hearing officer held that the designated doctor's certification of MMI is invalid; that claimant was not precluded from contesting MMI; that claimant has not reached MMI; and that claimant has suffered disability from December 28, 1991, to the date of the hearing.

The appellant, hereinafter carrier, appeals the hearing officer's determination that the certification of MMI was not valid because the great weight of the medical evidence is contrary to the designated doctor's finding. The respondent, hereinafter claimant, essentially argues that the hearing officer's decision is correct and should be upheld.

DECISION

We affirm the hearing officer's decision and order.

The claimant, who had worked for (employer), for 17 years, injured her back when she picked up a table on (date). She was originally sent to the employer's physician who examined her (but ordered no x-rays or other diagnostic tests) and sent her back to work. Because she continued to have problems, she went to her family doctor who took x-rays and diagnosed a herniated disc. He referred her to (Dr. D) who became her treating doctor and who treated her conservatively; when it became apparent that the conservative treatment was not working, he scheduled her for surgery on August 5, 1991. Just before the surgery, claimant found out that the carrier would not approve the surgery without a second opinion. The claimant was seen by (Dr. S), a neurologist, on August 27th for a second surgical opinion, and on that date he gave his opinion recommending against surgery. (Dr. S stated the claimant had subjective complaints with no objective abnormalities on the clinical examination, and that in spite of evidence of disc herniation, there were no clinical correlating signs. He said he also did not recommend surgery because the claimant reported neck pain which would not be relieved by lumbar spine surgery.) Dr. S also completed a Report of Medical Evaluation (Form TWCC-69) certifying that the claimant had reached MMI on August 27th with zero percent impairment. Dr. S wrote on November 5th that he had reviewed a myelogram and CAT scan performed on September 19th, but stated that his conclusions of August 27th remained in effect because of the absence of nerve root impingement. Carrier's case manager said Dr. S's report was sent to Dr. D for his concurrence or disagreement, but that Dr. D did not respond.

At some point thereafter, (Dr. X) was appointed by the Commission as designated doctor. In a TWCC-69, Dr. X wrote, in part, "c/o [complains of] back pain & right leg pain. No hard signs of radiculopathy. Normal back motions. Good reflexes. Minimal pain with right SLR. . . . Myelogram is negative. CT scan show (sic) right side herniated disc L5-S1 with minimal nerve root displacement at L5-S1 . . . MRI show (sic) spondylolysis (sic) and Grade I spondylolisthesis. This patient has continuing back pain with some leg pain. No hards (sic) sign of radiculopathy. As she has failed conservative treatment I feel she would benefit from a discectomy & fusion at L5-S1." Dr. X, however, found MMI as of December 27, 1991, with a 10% impairment rating.

Carrier's case manager, (Mr. J) testified that standard procedure would be to send to claimant a TWCC-21 (Payment of Compensation or Notice of Refused/Disputed Claim) showing payment of impairment income benefits (IIBS) based upon a finding of MMI and an impairment rating, along with the doctor's TWCC-69. (The initial TWCC-21 prepared by carrier in this case, which indicated it had been sent to claimant, stated in part, "[c]lmt reached MMI on 12-27-91 with 10% impairment rating, payment will resume as IIB's (sic))." The claimant testified that she received the TWCC-21 and Dr. X's report, but that she did not understand the significance of a finding of MMI and did not dispute Dr. X's findings because she did not know she was required to do so.

After seeing Dr. X, the claimant continued to treat with Dr. D, who on July 27, 1992, certified claimant reached MMI with a 10% impairment rating. At that time Dr. D wrote, "[claimant] continues to complain of back pain . . . she continues to be symptomatic, there is no neurological deficits and she basically has been stable in her complaints for the past six months. I think she will continue to improve. She may require back fusion. There is no evidence that is necessary at this point. I do not know when she will, or if she ever will, improve over what she is now." Elsewhere on the TWCC-69 Dr. D wrote, "I feel that [claimant] has reached maximum medical benefit that she will receive without surgery and I do not feel surgery is indicated at this point . . ." Nevertheless, Dr. D performed a disc fusion on claimant in October of 1992. On November 19th, Dr. D wrote that claimant's "previous disability ratings are premature in view of her recent surgery and they have to be revised somewhere in the future."

On February 16, 1993, the Commission's benefit review officer ordered Dr. X to re-examine the claimant to determine whether he wanted to withdraw his December 1991 findings. On March 16, 1993, the carrier objected to such second examination, arguing that Dr. X's assignment of MMI and impairment had become final because not disputed within 90 days. Dr. X nevertheless reexamined the claimant on March 29th, stating on that date that the claimant was five months status post-operation and "should reach MMI after this operation at six months. At that time I would estimate her disability as 10% of the spine." On April 1st Dr. X wrote the carrier in part as follows: "In my opinion, this patient had reached MMI when I examined her in Dec of 1991, as she did not want surgery. As the

patient had surgery, if the surgery is "allowed" I would expect MMI after surgery at the most 24 months (104 weeks) and at that time the impairment would still be 10% . . . Based on the exam on 12/27/91, I do not feel that her MMI declaration was premature. . . . Follow (sic) Oct 92 surgery, I would declare MMI at six months. I would again, expect impairment at 10%." At the hearing, the claimant denied telling Dr. X that she refused to have surgery.

In his discussion, the hearing officer characterized the threshold inquiry as "whether or not the certification and assessment of impairment are valid." Stating that the designated doctor's report must be "unambiguous and derived from unassailable logic," the hearing officer said that Dr. X's first TWCC-69, which certified MMI while stating the claimant would benefit from further treatment, "does not boast these qualities." Further, he said, the designated doctor's suggestion that the claimant refused surgery "flies in the face of the facts of record" which indicate the claimant was preparing to undergo surgery on August 5, 1991. Finding that the great weight of medical evidence is contrary to the designated doctor's finding of MMI, and that claimant has not reached MMI, the hearing officer determined that whether or not claimant timely disputed MMI is irrelevant.

In its appeal the carrier challenges the hearing officer's determinations on the issues of MMI and impairment and timely dispute (it does not appeal the hearing officer's finding that the claimant had disability). The carrier argues that the requirement of Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.5(e) (Rule 130.5(e)), that "the first impairment rating assigned to an employee is considered final if the rating is not disputed within 90 days after the rating is assigned," makes Dr. X's original assignment of MMI and impairment final, and that there are no exceptions to this rule. Carrier further denies that the rule imposes upon it any duty to give the claimant notice that she must dispute the impairment rating within 90 days, but also argues that the claimant's undisputed receipt of documents (including the TWCC-21 and Dr. X's TWCC-69), as well as the change in the amount of benefits received, constituted notice. While the carrier argues that a finding in its favor on this issue makes the second issue moot, it also contends with regard to the second issue that the great weight of the medical evidence--which included Dr. S's report, and Dr. D's later agreement with Dr. X--was not against the designated doctor's findings.

We need not decide the timely dispute issue with regard to Dr. X's opinion, because Rule 130.5(e) does not apply to Dr. X in this case. As noted above, that rule says the first impairment rating is considered final if not disputed within 90 days; as noted earlier in this opinion, it was Dr. S who assigned the first impairment rating to this claimant. The finality of Dr. S's opinion, however, was not raised at the hearing nor on appeal, and we will not address it here.

With regard to the appealed issue of whether the great weight of medical evidence is contrary to the designated doctor's opinion, we find supportable the hearing officer's determination that it was so overcome. Dr. X's original determination of MMI and

impairment apparently was based, as he stated in later correspondence, upon his belief that the claimant did not want surgery, a finding that was undercut by both prior and subsequent evidence (claimant's scheduled surgery in August 1991; her pursuing, at carrier's request, a second surgical opinion; and her decision to go ahead with the surgery in 1992). Further, upon order of the Commission, Dr. X reexamined the claimant in 1993; while not retreating from his December 27, 1991, opinion based upon the facts as he understood them at that time, he concurred in the surgery and estimated post-surgical MMI dates. His own reassessment of claimant's condition is strong medical evidence contrary to his first opinion; a designated doctor can, and many times should, amend his original opinion because of matters coming to his attention subsequent to his determination of MMI and impairment. Texas Workers' Compensation Commission Appeal No. 92441, decided October 8, 1992; Texas Workers' Compensation Commission Appeal No. 93207, decided May 3, 1993. In addition, claimant's treating doctor, who found MMI and impairment in July 1992, later recanted that opinion. Based upon the foregoing, which involves more than a mere balancing of the evidence, Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992, we find supportable the hearing officer's determination that the great weight of the other medical evidence is to the contrary of the designated doctor's report, and that the claimant has not reached MMI. Article 8308-4.25(b), 4.26(g).

We affirm the decision and order of the hearing officer.

Lynda H. Nesenholtz
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Susan M. Kelley
Appeals Judge